Facey Medical Group

*EMRN:*
*HCL:*

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

| | | |
|---|---|---|
| ☐ Mission Hills (Central ROI) | 11211 Sepulveda Blvd. Suite 120, Mission Hills, CA 91345 | (818) 365-9531 |
| ☐ Behavioral Medicine | 11165 Sepulveda Blvd., Mission Hills, CA 91345 | (818) 837-5780 |
| ☐ Canyon Country | 17909 Soledad Canyon Road, Canyon Country, CA 91387 | (661) 250-5200 |
| ☐ Copper Hill | 27924 Seco Canyon Road, Ste. 101 Santa Clarita, CA 91350 | (661) 513-2100 |
| ☐ Northridge | 18460 Roscoe Blvd., Northridge, CA 91324 | (818) 734-3600 |
| ☐ Porter Ranch Plaza | 19950 Rinaldi St., Northridge, CA 91326 | (818) 837-5715 |
| ☐ San Gabriel | 207 S. Santa Anita St. San Gabriel, Ca. 91775 | (626) 576-0800 |
| ☐ Simi Valley | 2655 First Street Suite 325, Simi Valley, Ca. 93065 | (805) 206-2000 |
| ☐ Valencia I | 26357 McBean Pkwy., Valencia, CA 91355 | (661) 222-2600 |
| ☐ Valencia II | 25775 McBean Pkwy., Valencia, CA 91355 | (661) 222-2600 |
| ☐ Valencia II | 23929 McBean Pkwy., Suite #200, Valencia, CA 91355 | (661) 222-2600 |
| ☐ Women's Center | 11165 Sepulveda Blvd., Mission Hills, CA 91345 | (818) 837-5770 |

**Type of access requested**: (If selecting more the one (1) option additional charges may vary)
☐Paper copy of records ☐CD Copy ☐Inspection of records (by appointment only *(allow 5 business days)*

**I request access as the** ☐ Patient ☐ Parent/Guardian ☐ Medical Power of Attorney ***(Proof of legal documentation is required)***

_____ _____ _____
Name of Patient (***Please print clearly***) AKA Date of Birth

_____ (____)_____
Address City State Zip Code Telephone

Please **SEND** medical information **TO**:
*(☐If same as above)*

_____
Name of Person or Entity to Receive Information

_____
Street Address

_____
City, State and Zip Code

_____
Telephone

Please **REQUEST** medical information **FROM:**

_____
Name of Medical Office/Provider

_____
Street Address

_____
City, State and Zip Code

_____
Telephone

**Duration:** This authorization will expire 12 months from the date signed.

**Revocation Process:** I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Facey Medical Group.

Rev. 01/31/2011

**SEND TO: Scan under ROI/Legal***
**REQUEST FROM: Scan under Outside Records***

**Right to Copy:** I have a right to receive a copy of the Authorization after I sign it.

**Re-Disclosure Statement:** I understand that once Facey Medical Group discloses my health information to the recipient, Facey Medical Group cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

**SPECIFY RECORDS TO BE RELEASED**

(Check the box and initial which type of information is to be released)

- ☐ All General Medical Information (from _____to _____). General medical records may include information of diagnosis and / or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.
- ☐ Information regarding specific injury or treatment (from_____ to _____)
- ☐ X-Ray (*check one or both*): (from_____ to _____) ☐ Reports ☐ Films ($18.00 per slide)
- ☐ Laboratory results (from_____ to _____)
- ☐ Mental health Only (from_____ to _____) _____
  ***(Psychotherapy sessions)*** Signature of Patient or Patient's Representative
- ☐ Other (Specify): _____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Facey Medical Group to use or disclose my health information in the manner described above.

_____ _____ _____

Date Signature of Patient or Representative Indicate Relationship (if not signed by patient)

☐Mail ☐Pick up ☐ Pick up at Facey Location_____ ☐ I give permission to _____ to pick up ***(ID verification is required for all pick up requests)***

**OFFICE USE ONLY**

Request processed by: _____ /_____ Date: _____

*Approved by(Please print and sign)*

If denied state reason why:_____

_____/_____ Date:_____

*Denied by (Please print and sign)*

**Incoming Records** Name of Provider:_____ Date: _____

Reviewed by MD/Practitioner:_____

**Bactes Use Only** (Bactes copied date stamp) ⟶

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